Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	DEPT OF MEDICAL ASSISTANCE SERVICES (DMAS)
Virginia Administrative Code (VAC) citation	12 VAC 30-120–211 through 12 VAC 30-120-249 (REPEALED) 12VAC 30-120-1000 et seq.
Regulation title	Waivered Services
Action title	Mental Retardation/Intellectual Disability Waiver
Date this document prepared	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

In a short paragraph, please summarize all substantive provisions of new regulations or changes to existing regulations that are being proposed in this regulatory action.

In addition to repealing the existing regulations and re-promulgating newly formatted regulations, this proposed regulation also includes changes to meet federal requirements resulting from the waiver renewal process. CMS requires states to assure the health and welfare of individuals enrolled in a home and community based waiver and to assure financial accountability and administrative authority in program operations. The major changes resulting from the federal waiver renewal process, and reflected herein, include: (i) the addition of person-centered planning, (ii) provision for a standardized instrument to document an individual's needs and required supports, (iii) provision of an annual risk assessment process, (iv) provision of the service facilitation process, (v) automation of the patient pay process, (vi) addition of standards for use by the community services boards of urgent care criteria, and (vii) addition of changes in nomenclature to reflect current terms used throughout the waiver renewal.

Key changes that were made in the current emergency regulations, as well as in these proposed regulations, included the use of current terminology (e.g., replace "mental retardation" with "mental retardation/intellectual disability"), changing the name of the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to the Department of Behavioral Health and Developmental Services (DBHDS), adding definitions for person-centered terms such as "Person-Centered Planning (PCP)," "Individual Support Plan," and "Plan

for Supports," adding the requirement for an annual risk assessment, requiring an additional comprehensive assessment to be completed every three years on a DBHDS-approved assessment tool, and removing the requirement that individuals participating in the consumer-directed service model must have a services facilitator (SF) but may optionally choose to work with a SF.

Pursuant to the authority of 42 CFR 440.230(d), DMAS is also incorporating new limits for State Fiscal Year 2012 for the coverage of assistive technology and environmental modification services. Because these services are currently authorized on a calendar year basis, this proposal will require service authorizations in six-months increments thereby maintaining current limits through June 30, 2011, and implanting the new limit on July 1, 2011.

DMAS also recognizes the national effort currently underway to eliminate all references to 'mental retardation' in the healthcare industry's lexicon. At such time as Congress amends the *Social Security Act* with such a language change, DMAS will modify its State Plan for Medical Assistance and related waiver regulations accordingly.

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Medicaid waivers are authorized by § 1915 (c) of the *Social Security Act* and are intended be a less costly way, as compared to institutionalization, of caring for such individuals' needs. This statute section permits the waiver of certain fundamental Medicaid requirements, such as state-wideness and comparability of the amount, duration, and scope of services. The state-wideness standard states that covered services must be available throughout the entire Commonwealth. The comparability of amount, duration, and scope of services standard states that services covered for mandatory groups of eligible persons cannot be of a lesser degree than those covered for optional groups and covered services must be provided to the same degree for all persons within each covered group. Waiver programs are permitted, pursuant to § 1915 (c) of the *Social Security Act*, to cover unique services to specifically designated populations of Medicaid recipients based on their medical needs.

This program is a waiver of federal comparability of services requirement because these covered waiver services are only provided to persons who qualify for this waiver program by being at risk of institutionalization. Most of DMAS' home and community based care waivers are

designed, due to the diagnoses of the various target populations, as medical care models. This MR/ID waiver is more uniquely a social service than a medical model, at the urging of DBHDS and the advocacy community.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.

This regulation is required in order to meet the Centers for Medicare and Medicaid Services (CMS) requirements for the renewal of the Mental Retardation/Intellectual Disability (MR/ID) Waiver (previously referred to as the Mental Retardation Waiver). DMAS covers these services pursuant to a waiver of certain federal requirements, permitted by application to CMS, the federal Medicaid authority. CMS approved the request for the renewal effective July 1, 2009; the current MR/ID waiver will expire June 30, 2014.

The MR/ID Waiver program provides supportive services in the homes and communities of persons with diagnoses of MR/ID or children younger than the age of six years who are at risk of developmental delay. This program permits these individuals to safely remain in their homes and communities rather than being institutionalized in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The MR/ID Waiver program currently supports 8,052 slots (one slot per waiver enrollee.

DMAS collaborates with the Department of Behavioral Health and Developmental Services (DBHDS), formerly known as the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), in the administration of this waiver. DBHDS has worked closely with DMAS on the referenced waiver submission as well as these proposed regulations.

Substance

Please briefly identify and explain new substantive provisions (for new regulations), substantive changes to existing sections or both where appropriate. (More detail about all provisions or changes is requested in the "Detail of changes" section.)

The regulations affected by this action are the Waiver Programs, specifically Mental Retardation/Intellectual Disability Waiver. The regulations at 12VAC 30-120-211 through 120-249 are being repealed and the regulations at 12VAC 30-50-1000 *et seq.* are being newly promulgated.

Prior to the latest referenced federal approval of waiver changes (during the routine waiver renewal process), this program was entitled the Mental Retardation Waiver. The same services were covered as are contained in these proposed regulations. The same waiver individual income and resource eligibility standards were used. The provider requirements were also the

same. The differences in these proposed regulations over the current regulations are discussed below.

CMS now requires that states use person-centered planning (PCP) in their waiver programs to ensure that individuals enrolled in the state's home and community based waivers fully participate in the planning for their services and supports. Virginia's Systems Transformation Grant and other complementary efforts have resulted in the development of certain core elements of a person-centered planning process for Virginia. Person-centered planning goes beyond the traditional individualized planning processes used in the waiver. The person-centered approach relies much less on the service system and focuses on the individual receiving waiver services and supports. To accomplish PCP across Virginia, these regulations incorporate the essential definitions and activities needed to implement PCP. These definitions include person-centered planning, individual support plan, plan for supports and use of a standardized assessment tool, which is discussed below. These definitions and activities further ensure these individuals' health, safety, and welfare are ensured and meet CMS' requirements for waiver renewal.

As part of the PCP process, DBHDS will identify one standardized assessment tool and schedule (every three years) to ensure consistency across Virginia in identifying individuals' needs for waiver supports and services. DBHDS will publish guidance documents for the MR/ID waiver that provide for this standardized assessment tool.

CMS and Virginia place great importance on the health, safety, and welfare of individuals enrolled in waiver programs. To this end, an annual risk assessment was included in the waiver renewal. This risk assessment will be conducted, and risk mitigation will be incorporated, into each individual support plan as a component of person centered planning.

Virginia, since 1997, has permitted certain of its covered waiver services (personal care assistance, respite care, and companion services) to be provided in a consumer-directed model in addition to the historically-provided agency-directed model. The agency-directed model uses enrolled provider companies who hire nurses, nurse aides, and assistants to render services to Medicaid recipients according to a provider-developed schedule and staffing assignments. The consumer-directed model permits the Medicaid recipient to be the employer (hiring, training, and firing) of his own assistant and schedule the assistant's services (work schedule) consistent with the recipient's needs, as they are documented in the recipient's approved plan of care now known as the Individual Support Plan.

Virginia's MR waiver regulations have historically required that an individual choosing the consumer-directed model for the delivery of personal care assistance, respite care and companion care services also must receive the services of a services facilitator. In CMS' most recent review of Virginia's MR/ID Waiver application for renewal, CMS instructed the Commonwealth that because services facilitation is a waiver service, waiver individuals have the right to choose whether or not to receive services facilitation. Therefore, Virginia removed the requirement from the waiver.

To ensure that the essential tasks related to the delivery of consumer-directed services continue to be performed, these regulations propose that the individual or the family/caregiver, as

appropriate, may perform those tasks (e.g., development of a plan of supports, submission of the plan for prior authorization, record documentation, etc.) themselves when services facilitation is not chosen by the individual or his family/caregiver. Also, as "services facilitation" is included in the waiver renewal as an optional service, rather than as an administrative activity, a definition is added herein.

CMS further directed Virginia to modify the process currently used to fill MR/ID waiver slots to ensure the uniformity of the statewide process. CMS is now requiring that Virginia, through DBHDS, develop uniform, statewide guidelines to be applied by community services boards (CSBs) and behavioral health authorities (BHAs) to identify those urgent waiting list individuals who are most in need of services when waiver slots become available. These proposed regulations create the DBHDS' authority to accomplish this federal directive.

These regulations include DMAS' conversion to an electronic information exchange between the local departments of social services, DMAS, and enrolled MR/ID service providers for determination of the patient pay requirement for waiver services.

The proposed regulation also includes technical changes to facilitate the enrollment and service provision processes in response to stakeholder input.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

This action poses no disadvantages to the public or the Commonwealth. These proposed changes make these regulations more consistent with the needs of individuals receiving services, providers of those services, and the two affected agencies' missions. The regulatory requirements have been clarified when appropriate to facilitate their application and to promote better understanding for users. The provisions have also been modified to reduce implementation costs for providers and the agency whenever possible.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal, which are more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

There is no locality in Virginia that bears a disproportionate material impact resulting from these regulations. These proposed regulations are consistent with the federally approved waiver changes.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

No localities are uniquely affected as these changes apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

DMAS is seeking comments on the regulatory action, including but not limited to 1) ideas to assist in the development of a proposal, 2) the costs and benefits of the alternatives stated in this background document or other alternatives, and 3) potential impacts of the regulation. The agency/board is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include: 1) projected reporting, record-keeping, and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Helen Leonard, Long-Term Care Division, DMAS, 600 East Broad Street, Richmond, VA 23219; telephone: 804-786-2149; fax: 804-612-0050; e-mail: IDwaiver@dmas.virginia.gov. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by the last day of the public comment period.

In the development of the proposed regulations, DMAS collaborated with DBHDS staff, as well as representatives from providers, consumers, families, and advocacy organizations. DMAS will continue to collaborate with the affected community as this process moves forward.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

The regulations require the use of the Supports Intensity Scale (SIS), an assessment instrument to comprehensively assess individuals' needs for supports and services received through the MR/ID waiver. DBHDS requested that this form be a part of the 2009 MR/ID federal waiver renewal and CMS approved it. The form supports the person-centered planning process required for waiver approval. The initial supply of this form has been purchased by DBHDS using grant funds. After July 1, 2012, DBHDS will request federal financial participation (FFP) for the administrative costs associated with the use of this form in the MR/ID waiver.

DBHDS provided the following cost estimates for the first year (FY 2012) of the use of the SIS form. Assessments using the SIS form must be performed every three years. DMAS has not independently verified these estimates.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source, and (b) a delineation of one-time versus on-going expenditures.	The cost for the purchase of the SIS will be a recurring cost. DBHDS estimates that 3,334 to 5,000 forms needed at a maximum cost of $100,308 total funds ($50,150 NGF share) for each state fiscal year. These estimates may need to be adjusted based on the number of waiver slots funded by the General Assembly.
Projected cost of the new regulations or changes to existing regulations on localities.	Persons whose services do not start within 30 days must be referred back to the local department of social services for re-determination of eligibility. There are 120 local agencies. It is not known how many waiver individuals will be affected by this require-ment.
Description of the individuals, businesses or other entities likely to be affected by the new regulations or changes to existing regulations.	Entities that are affected would be those who render (approximately 1,825 providers) and receive MR/ID Waiver services. In SFY08, 7,306 (as of 12/2009) individuals received MR/ID Waiver services. Providers include home health agencies, community services boards, and private providers of crisis stabilization, day support, in-home residential support, personal care, durable medical equipment, prevocational services, respite care, skilled nursing, supported employment, therapeutic consultation, and transition services.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or	Approximately 1,621 small business providers will be affected by this regulation.

has gross annual sales of less than $6 million.	
All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and do include all costs. Be sure to include the projected reporting, record-keeping, and other administrative costs required for compliance by small businesses. Specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	There should be no additional costs for affected individuals, businesses, or other entities. There will be a learning period for person-centered language and the forms that are replacing former ones, so there may be costs associated with training, but only at the outset. Technical assistance will be available from both DMAS and DBHDS which has already conducted training for many of its providers, including CSB staff.
Beneficial impact the regulation is designed to produce.	1. Individuals receiving MR/ID Waiver services will experience a new level of independence and control over the services they receive and how they are received through person centered planning. 2. The process for managing the DMAS-225 is streamlined with fewer providers being required to maintain copies of the form. 3. The qualifications for QMRPs are expanded. 4. Providers have control over the qualification process for personal and respite assistants, being required to ensure that staff meets general areas of knowledge, skills, and abilities rather than following a set curriculum.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

There were no appropriate alternatives other than meeting the CMS requirements for the approval of the MR/ID Waiver renewal. Federal regulations require that each home and community-based waiver be renewed every five years, and CMS changes must be made in order for the Commonwealth to continue to receive federal matching funds for the provision of the waiver services to eligible individuals. Such revisions have been designed to address the problems that have been identified by those who are affected by the regulations, such as (i) expanding the educational requirements for Qualified Mental Retardation Professionals to permit more providers to participate in the waiver, and (ii) not requiring providers to retain the DMAS-225 form in their records.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

Many of the providers who are governed by these regulations may be considered small businesses, including home health agencies, services facilitation providers, and durable medical equipment providers. Changes have been made where possible to facilitate a reduction of paperwork for those providers. These regulations do not exempt small businesses from all or any part of the regulations. However, the regulations provide some requirements for specific types of service providers and, in some cases, reduce the regulatory burden on these providers.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' Notice of Intended Regulatory Action was published in the 11/23/2009 Virginia Register (VR 26:6) for its public comment period from 11/23/2009 to 12/23/2009. Please note that the former regulatory section on the MR/ID waiver at 12VAC30-120-211 through 12VAC30-120-249 is being repealed and replaced with new sections 12VAC30-120-1000 through 12VAC30-120-1090. As such, the specific recommendations for detailed language changes may not be readily apparent. Comments were received from the following:

Commenter	Comment	Agency response
Jennifer G. Fidura, Fidura & Associates, Inc., and Mary Ann Bergeron, Executive Director, Va. Association of Community Services Boards	12VAC30-120-213. The terminology used in this Waiver has been updated to make the term intellectual disability synonymous with (and preferable to) the term mental retardation. The diagnostic requirements outlined in 213 A. 1. & 2. do not reflect that change.	The agency concurs with this comment and has addressed this oversight.
	12VAC30-120-215 B. 2. b. If the DBHDS approved	Per DBHDS, the SIS

	assessment (the AAIDD-SIS) is the only tool to be used and replaces the functional assessments currently in use; it will be difficult to demonstrate "a need for each specific services" as required. The SIS should be one of the instruments used, but providers should not be limited in their use of other more appropriate instruments.	will be the required assessment instrument. If providers wish to conduct or utilize other additional assessments, they are free to do so but the AAIDD-SIS will be required.
	12VAC30-120-215 D. 5. This should be revised to read "The case manager must obtain an updated DMAS 225, designate *and inform* a collector of patient pay when applicable and forward a copy of the updated DMAS-225 form to ~~all service providers and~~ the consumer-directed fiscal agent if applicable." See other comments below.	The agency concurs with this comment and has addressed this comment.
	12VAC30-120-223 D. 2. d. This language should be modified to match the language in 225 B. 7. to indicate that compensation will not be permitted for services "effective the date that the criminal record check confirms . . . "	The agency concurs with this comment and has addressed this comment.
	12VAC30-120-223 D. 7. a., 229 F. 3. a., 233 D. 10. a., 237 D. 3. a., 241 D. 4. a., and 247 D. 2. a. These references to the assessment instrument (the AAIDD-SIS) which is scheduled to be completed triennially, should include the following language "A copy of the DBHDS-approved assessment, *or documentation of the provider's attempts to obtain a copy* . . . "	This language will be considered for addition to the provider manual that will be published when the regulation becomes final.
	12VAC30-120-223 D. 7. g., 229 F. 3. h., 233 D. 10. h., 237 D. 3. i., 241 D. 4. e., 245 D. 4. h., 247 D. 2. f., and 249 D. 5. Unlike the DMAS-122 form, the DMAS 225 form is not completed on an annual basis; it may not be possible for the provider to know when a new DMAS 225 has been completed and, therefore, they could neither have the "most recent" nor know to request the "most recent." This will place an undue burden on the providers to document information they have no way to know and may place a provider at risk of monetary penalty in the event of an audit.	Management of the DMAS-225 was discussed at a meeting of agency staff and stakeholders and will be revised accordingly. DMAS maintains an electronic notification system for providers' use.
	12VAC30-120-223 D. 7. g., 229 F. 3. h., 233 D. 10. h., 237 D. 3. i., 241 D. 4. e., 245 D. 4. h., 247 D. 2. f., and 249 D. 5. The DMAS 225 does not convey the patient pay amount and, therefore, does not contain any information useful or relevant to the provider; it should	DMAS maintains an electronic notification system for providers' use to obtain recipient

	not be required to be contained in the provider's records, but should be maintained in the Case Manager's record.	eligibility, patient pay and other relevant information.
	12VAC30-120-229 F. 3. c. & d. If the word "type" refers to the types of service described in 229 C. then documentation of the "individual's response to . . . as agreed to in the Plan for Supports" should be sufficient to show that the type of service was that as approved in the prior authorization request. Requesting this as a separate item may place a provider at risk of monetary penalty in the event of an audit.	For purposes of Quality Management Reviews and utilization review audits, the agency prefers that the type of service continue to be included.
	12VAC30-120-233 D. 7. a. (2) While I do not object to the intent, documentation of the skill to read and write English may be lacking in a hiring package as it is generally considered discriminatory to apply this standard to only select applicants. The lack of documentation to this specific point may place a provider at risk of monetary penalty in the event of an audit.	Both DBHDS and DMAS believe this is a provider responsibility. It would be difficult to follow the Plan for Supports and document rendered services if provider staff does not meet this minimal require-ment.
	12VAC30-120-241 B. 3. and 247 B. 3. Add the following phrase "Providers must participate <u>*as requested*</u> in the completion . . . " to the first sentence and then add "<u>*Documentation must be maintained in the Case Management record of attempts to schedule the participation and the results."*</u>	The first suggestion to add "as requested" has been completed; it is felt that the second suggestion is better suited to the provider manual when it is updated.
	12VAC30-120-241 D. 4. d. Because of the allowance for average daily billing; the phrase "the amount of time in services" should be deleted. Attendance recorded on a daily basis may not satisfy that requirement and may place a provider at risk of monetary penalty in the event of an audit.	The agency concurs with this comment and has addressed this comment.
Kim Holmes	Individual and Family Developmental Disabilities DD Support Waiver: This waiver states that it has skilled nursing services. The words are misleading, it means that a skilled nurse will come to your home to teach you how to care for your child with the need for nursing. I was on the list for six years. I need a skilled nurse to provide services not to teach me. I am a nurse that needs to work. The wording needs to be changed. Very misleading.	This comment does not pertain to the regulations in comment period. However, this issue will be referred to the DD waiver staff for consideration.

Ben Kleiner	The DMAS 225 does not convey the patient pay amount and, therefore, does not contain any information useful or relevant to the provider; it should not be required to be contained in the provider's records.	The use of the DMAS-225 has been discussed with stakeholders and language changed.
Call Center Outsourcing	This action conforms the MR Waiver regulations to the recently federally approved MR Waiver Application. This is really a good move.	DMAS appreciates the comment.
Sherry Confer, Deputy Director, Virginia Office for Protection and Advocacy	VOPA is pleased that DMAS and DBHDS are changing the regulations to reflect the required Person Centered Planning practices. We would strongly encourage you to eliminate the term mental retardation and use intellectual disability. The Centers for Medicaid and Medicare services has noted the shift in terminology and Virginia should be consistent.	At this juncture, DMAS is advised to keep both terms until Congress changes the *Social Security Act*, or CMS issues some other formal mandate, to use only "intellectual disability."
	The change of Consumer Service Plan to Individual Support Plan is a more person centered planning term. However the change does not appear to encompass the health care needs of the individual who receives waiver services. The health care needs of the individual should be included in the Individual Support Plan.	The new definition for the Individual Support Plan is intended to include all services needed by the individual, including health care needs.
	For individuals who select to use the consumer directed services under this waiver, Virginia should have more available supports and resources in place to all the individuals to direct their services in an effective manner. The regulations should include the maximum amount of consumer control, balanced with safeguards to ensure the continued health and safety of the individual. Individuals using waiver services need to be afforded the full opportunity to make service delivery choices.	The agency agrees that all available and allowable supports and resources should be in place to help individuals direct their services.
	The waiver should include more options of consumer directed services.	DMAS, in collaboration with DBHDS, will consider this for the next waiver renewal process to the extent that funding is available.
	The emergency regulations respond to CMS requirement to have a statewide consistent method for	The agency agrees.

	the allocation of waiver slots. DBHDS should develop a process that is transparent to individuals and families.	
	The emergency regulations do not include a definition of risk assessment nor provide any guidance on conducting the risk assessment or risk mitigation. DMAS and DBHDS must ensure maximum participation of the individual in any assessment and development of plans for risk mitigation. As well, DMAS and DBHDS should challenge the individuals themselves to risk growth and development. Family members, assessors and mitigation planners should allow the individual the highest possible safe level of self-direction and choice. Increasing independence and enhancing community integration cannot occur within protective cocoons.	The agency concurs with this comment and a definition of 'risk assessment' has been included in the proposed regulations.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

This regulatory action will implement requirements for providers of MR/ID Waiver services. The standards provide the means for the agency to provide regulatory oversight in accordance with the law. It is also the basis for the accountability of services that are provided to a vulnerable population. This should have a positive impact on the stability of individuals and their family/caregivers receiving services from providers by promoting the quality of those services and an acceptable standard of care. The regulations encourage family involvement in services and should not have any negative impact on the authority of parents, self-sufficiency or individual responsibility, marital commitment, or family income. The MR/ID Waiver encourages self-pride and an assumption of responsibility for oneself, particularly when an individual elects the consumer-directed model of service delivery.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact if implemented in each section. Please detail the difference between the requirements of the new provisions and the current practice or if applicable, the requirements of other existing regulations in place.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all provisions of the new regulation or changes to existing regulations between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

The state regulations that are affected by this action are Waiver Services, Part IV, Mental Retardation Waiver (formerly 12 VAC 30-120-211 through 249) are being repealed and re-promulgated as 12VAC30-120-1000 through 1090 for the permanent regulations.

Changes to the previous regulation made by the implementation of the emergency regulation are outlined below:

- Effective July 1, 2009, DMHMRSAS changed its name to the Department of Behavioral and Developmental Services (DBHDS).

- Added definition for interrelated terms, "Person-Centered Planning (PCP)," "Individual Support Plan," and "Plan for Supports." Remove definitions for "Consumer Service Plan (CSP)" and "Individual Service Plan." Ensure that "individuals" is used consistently instead of "recipients." These changes reflect a person-centered approach as required by CMS as well as reflecting a national trend toward using the more person-centered terminology of "intellectual disability" and moving away from the use of "mental retardation."

- Replaced the term "Mental Retardation (MR)" with the term "Mental Retardation/Intellectual Disability (MR/ID)" – MR and ID are synonymous in definition and classification. This change reflects the person-centered focus incorporated into the waiver renewal application.

- Effective March 1, 2009, the DMAS-122 became obsolete. With the exception of patient pay amount (which is now automated), the DMAS-225, the Medicaid Long-Term Care Communication Form, replaced the DMAS-122. Patient pay will be determined through information in the Medicaid Management Information System that providers can access. This process is described in the waiver renewal application.

- In 2007, the AAMR changed its name to the American Association on Intellectual and Developmental Disabilities (AAIDD). AAIDD's definition for MR/ID is in the waiver renewal application.

- Changed the definition of QMRP and for providers of crisis stabilization to include individuals with a bachelor's degree in a field other than human services, and who also hold an advanced degree in a human services field, to meet the qualifications. This is needed for certification and mirrors the federal definition of QMRP reflected in the waiver application.

- Added a requirement for annual risk assessment and incorporated risk mitigation into the Individual Support Plan. This addition is in response to a CMS requirement that it be included during the waiver renewal process.

- Included language requiring a comprehensive assessment to be completed every three years on a DBHDS-approved assessment tool and retained language regarding the level of functioning survey being completed annually. This is in accordance with CMS requirements in the waiver renewal process.

- Defined the method of communicating in DMAS guidance documents to allow for electronic communications.

- Removed the requirements that individuals participating in the consumer-directed service model must have a services facilitator to make this optional for the individuals. Services facilitation is now a covered waiver service and federal law prohibits states from requiring an individual to receive a waiver service. This change is reflected in the renewal application.

- Changed the regulation to reflect the process described in the waiver renewal process to secure criminal background checks and child protective services checks. The program's fiscal agent now performs this activity.

- Where possible, for waiver individuals who are younger than 21 years of age, AT, personal care, skilled nursing services, and all other services having common definitions with EPSDT, will be provided through the EPSDT State Plan benefit.

- Provides for involuntary disenrollment from consumer directed model of service delivery under certain circumstances related to health, safety, and welfare.

In addition to the above changes made by the emergency regulation and that are proposed to be retained in the permanent regulation, the following section identifies changes suggested to the existing regulations since the implementation of the emergency regulations. Note that the former regulatory section on the MR/ID waiver at 12VAC30-120-211 through 12VAC30-120-249 sections are being repealed and replaced with new sections 12VAC30-120-1000 through 12VAC30-120-1090.

Section number	Proposed requirements	Other regulations and law that apply	Intent and likely impact of proposed requirements
211 through 249	Existing regulations		Being repealed
1000 Defini-tions (Former-ly Section 211)	Definitions for "consumer-directed services facilitator," "day support," "individual support plan," "residential support services," "risk assessment," "services facilitation," "supported employment," and "transition services" have been added and/or revised to reflect person-centered principles and practices, including the replacement of	Centers for Medicare and Medicaid Services (CMS) approved MR/ID	Revised and updated definitions for consistency within the MR/ID Waiver and between other waivers. The purpose is to provide a complete and concise listing of terms related to the provision of the MR/ID Waiver. The

	"training, assistance, and specialized supervision" with "skill-building, supports, and safety supports." Definitions for "prior authorization" (replaces "preauthorization"), and "fiscal/employer agent" have been added to reflect current practice. Various definitions have been revised or edited for clarification and simplification and new definitions are added. The definitions of Registered Nurse and Licensed Practical Nurse have been expanded to provide for multi-state licensure.	Waiver renewal.	intellectual disability community has been advocating for the use of person-centered language, and CMS now requires its use. Recognizing nurses who hold licenses from other states is intended to address nursing provider shortages that exist in some areas in the Commonwealth.
1005 Waiver description and legal authority	This is a new section describing federal authority of DMAS to administer the waiver and the population served and under what circumstances.		This section is being added to all Medicaid waiver regulations for consistency.
1010 Individual eligibility requirements (Formerly addressed in 12VAC30-120-215)	In this section and those following, "will," "may," and "must" are replaced with "shall," as appropriate. Delete repeated language regarding guardianship fees. Revise the order of actions that occur for the purposes of assessment and enrollment after there has been a determination of the individual's diagnostic and functional eligibility (as described in previous sections 12VAC30-120-215B.2. and C.3). The timing of the completion of the DBHDS-approved assessment and Personal Profile, followed by a person-centered planning meeting, are defined. Amend the procedure for the case manager's role in obtaining the DMAS-225 from DSS		Language is amended to comply with the Registrar's Style and Procedure Manual regarding the use of these terms. Delete repetitious language. Reorder process in order that it occurs in practice. This change is in response to concerns expressed by

	and designating and informing in writing a service provider to be the collector of patient pay. The designated provider shall monitor the automated DMAS-designated system periodically for changes (formerly in 12VAC30-120-215C.2).		providers that the process was too cumbersome. Process was streamlined in coordination with provider representatives.
	In this section and throughout, DBHDS is changed to the "state-designated agency or its contractor."		Statement allows for changes in the entity that performs certain functions without the need for additional regulatory action.
	Adds to new Section D.5. "of receipt of enrollment confirmation from DHBDS."		Clarifies what is meant by "within 30 days**."** Provides for referral back to local dss agencies for eligibility review consistent with federal requirements.
	"Service goals and objectives" is changed in this section and throughout to "the individual's desired outcomes and support activities". In addition, "goals" is changed to "desired outcomes" or "outcomes."		Changes language to a person-centered focus.
	New text defines when the DBHDS-approved assessment is to be completed (i.e., at least every three years or when the individual's support needs change significantly).		Addition provides guidance as to the periodicity of the completion of the required DBHDS-approved assessment (SIS) for all individuals in the MR/ID Waiver.
	In this section and throughout, case managers shall conduct a minimum of quarterly on-site home visits to individuals receiving MR/ID Waiver services who reside in DBHDS-licensed sponsored residential homes.		Change recommended by DBHDS to conform to that agency's licensing require-ments and to further protect the health, safety and welfare of individuals receiving waiver services.

	Provision is made for involuntary dis-enrollment from consumer-directed services when specified conditions are identified. Provision is made for cases in which services are not initiated in a timely manner for the waiver individual to be referred back to the local department of social services for Medicaid eligibility re-determination.		DMAS is addressing identified issues in the consumer-directed services. This requirement comports with Medicaid eligibility policy.
1020 A Covered services	New general requirements setting out the specific services that will be covered in this waiver; provisions for voluntary/involuntary disenrollment of consumer directed services.		Covered services statements added for clarity to reader; provisions for voluntary/ involuntary disenrollment added to address identified issues in this service model, including requirement that case manager/services facilitator document and take action.

1020 Covered services; limits on covered services (Formerly addressed in 12VAC 30-120-213A-B and in Sections 221 through 249 that addressed individual waiver services)	**Assistive technology (formerly 12VAC30-120-221)** Limit is proposed for January-June, 2011, for $5,000 and for July-December, 2011, for $3,000 for this service. Add to former 12VAC30-120-221C that medical equipment and supplies required for individuals under age 21 that can be covered under the State Plan must be furnished through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. AT providers must demonstrate, as necessary, the AT to the individual or family caregiver. **Companion services (formerly 12VAC30-120-223)** Abbreviations for licensed practical nurse (LPN) and registered nurse (RN) are used.	State Plan for Medical Assistance	Dividing CY 2011 in half permits recognition of receipt of federal stimulus funds and reduces expenditures in the second half of the year in response to budget reductions. Clarifies existing requirement that AT for individuals younger than 21 years that can be covered under EPSDT be rendered via that alternative program. Clarifies when the AT must be demonstrated "as necessary." Simplification of language; complies with Registrar's

			Style and Procedure Manual.
	The regulatory reference for the services facilitator is added.		Provides clarification of the services facilitators' duties.
	Adds provision for attendants to not be reimbursed if they have a local DSS finding of abuse, neglect.		Provides additional safety check for the benefit of the waiver individual.
	Consumer-directed services (formerly 12VAC30-120-225)		
	"Care" is changed to "support."		Changes language to a person-centered focus with less of a medical model of care and consistent with the federal waiver renewal.
	Change "employer" to "employer of record" or "EOR."		Updates language to reflect current practice.
	Add that the case manager shall document in the Individual Support Plan the individual's choice for the CD model and whether the individual can serve as the employer or if there is a need for a family/caregiver to serve as the EOR on behalf of the individual.		Adds language that assures compliance with CMS regulation.
	Change that CD services facilitation is a separate waiver service used in conjunction with CD personal assistance, respite, or companion services.		To comply with CMS ID/MR Waiver renewal approval.
	Clarify that, if an individual does not select a services facilitator, the person or family/ caregiver who is chosen to perform all of the duties and meet all of the requirements identified for services facilitation shall not be paid by Medicaid for performing these duties.		Clarification made regarding payment to a person or family member/ caregiver who is not a Medicaid-enrolled services facilitator.
	Re-orders the requirements of a CD services facilitator.		Per CMS request, the requirements for a CD

			services facilitator are put before the conditions that are preferred.
	"Quarterly" is defined as "every 90 days."		Clarification of quarterly time period is needed for quality management reviews.
	Day Support (formerly at 12VAC30-120-229)		
	Service description is updated.		Language revised to conform to person-centered language.
	Consolidate documentation requirements related to the attendance log, amount of time in services, and specific information regarding the individual's response to various settings and supports.		Language consolidated for clarity.
	Intensive day support services, when requested, are to be included on the Plan for Supports.		Defines where documentation is to be included for purposes of Quality Management Review.
	Environmental modifications (formerly at 12VAC30-120-231)		
	Defines that modifications can be made to an automotive vehicle if it is owned by the individual, a family member with whom the individual lives or has consistent and ongoing contact, or a non-relative who provides primary long-term support to the individual and is not a paid provider of services.		Clarifies situations where a vehicle modification can be approved.
	Revise that the dollar limit on environmental modifications shall be by calendar year instead of service plan year. Provides that the one year service limit applies to persons who may change waivers during the course of that year.		Use of calendar year makes administration of this benefit easier; clarifies that a waiver individual is only entitled to dollar amount regardless of whether he stays in one waiver or changes waiver.

	Limit is proposed for January-June, 2011, for $5,000 and for July-December, 2011, for $3,000 for this service.		Dividing CY 2011 in half permits recognition of receipt of federal stimulus funds and reduces expenditures in the second half of the year in response to budget reductions.
	Personal assistance/respite (formerly 12VAC30-120-233)		
	Sets out requirements for waiver individuals to be approved to receive this service and limits on the covered service.		Addition made for clarity.
	When episodic respite care is provided, the supervisor or services facilitator, as appropriate, shall review the utilization of respite services either every six months or upon the use of 100 respite services hours, whichever comes first.		This is a change from a supervisory visit every 30 to 90 days to account for instances where respite is not provided on a routine basis. Budget change incorporated.
	PERS (formerly at 12VAC30-120-235)		
	The standards for PERS equipment is stated to be that approved by the Federal Communications Commission and Underwriters' Laboratories (UL).		Detailed location of standards in the UL safety standards are eliminated as they can be subject to change.
	Prevocational services (formerly at 12VAC30-120-237)		
	Sets out what is covered under this service and how much provider time will be counted as a block of time for billing purposes.		New text is not substantially different from text being replaced.
	Residential support services (formerly at 12 VAC30-120-241)		
	"Feeding" is added to "eating," and "programming" is changed to "services."		Language revised to conform to person-centered language.
	Documentation requirements related to the attendance log, amount of time in services,		Language is consolidated for clarity.

	and specific information regarding the individual's response to various settings and supports are consolidated.		
	Requires that intensive day support services, when requested, be included on the Plan for Supports.		Defines where documentation is to be included for purposes of quality management review.
	Respite services (formerly at 12 VAC30-120-233)		
	Separates service from personal care and permits coverage in either the agency-directed model or the consumer-directed model.		No substantial changes over regs being repealed.
	Services facilitation (formerly at 12 VAC 30-120-225)		
	Can no longer be mandated for persons who elect the consumer-directed model of care.		Federal restriction imposed during the waiver renewal process.
	Skilled nursing services (formerly 12VAC30-120-245)		
	"Hourly units" are changed to "in accordance with the DMAS fee schedule" to address how reimbursement will be made.		CMS requested a change to eliminate the use of "units" and to establish a fee schedule.
	Supported employment (formerly 12VAC30-120-247)		
	"One-hour units" is changed to "The unit of service shall be one hour" to address how reimbursement will be made.		CMS requested a change to the language of how reimbursement is made.
	Therapeutic consultation (formerly 12VAC30-120-249)		
	Sets out what is covered and what standards must be met in order for a waiver individual to be approved for this service.		To ensure that service is rendered to individuals who require it and qualify for it.

	Transition services Transition services language added for description, criteria, service units and limitations, and provider requirements for transition services.		Transition services became a part of the MR/ID Waiver through promulgation of the Money Follows the Person Program final regulations effective 7/2008.
1040 General requirements for participating providers. (formerly in Section 217)	Change wording related to the provider being responsible to comply with applicable DMAS provider manuals. Reference to SIS form and federal List of Excluded Individuals and Entities (LEIE) added to provider requirements. Items related to communication with other entities about the individual receiving services must be included in the record.		Simplifies language. Provision added that providers are responsible for complying with participation standards and that failure to comply may result in the termination of their provider agreements. Subsection G added specific functions for the fiscal employer/agent to provide more detail about this service. Expands and clarifies which contacts and documents must be included in the record.
1060 Participation standards for provision of services; provider requirements. (Formerly addressed in 12VAC30-120-221 through	Change the effective date of notice of a provider's intent to discontinue services from 12 days to at least 10 business days. **Companion services (formerly 12VAC30-120-223)** Define that a criminal record check shall be requested by the vendor fiscal/agent for CD services and that the companion shall not be reimbursed for services provided effective on the date and thereafter that the criminal record check verifies that the companion has been convicted of a crime pursuant to § 37.2-416 of the *Code of Virginia*. Add to the list of conditions prohibiting compensation for services when an attendant is determined by	§ 37.2-416 of the *Code of Virginia*	This corrects a change that was overlooked in previous revisions. Conforms language to current practice where the fiscal/agent conducts the criminal background check (including CPS checks) for individuals receiving CD companion services and defines when reimbursement can be made to the provider rendering services.

249 that addressed individual waiver services)	a local DSS to have abused or neglected elderly or incapacitated persons. **Consumer-directed services (formerly 12VAC30-120-225)**		
	Add that the supervisor or case manager, as appropriate, shall determine and document why no providers other than family members are available to care for the waiver individual.		Existing regulations require that family members not serve as companions unless there is objective written documentation as to why no other providers are available to provide the service. This amendment clarifies who is responsible for this determination.
	Define that a criminal record check and Child Protective Services (CPS) Central Registry Check (for services provided to minors) shall be requested by the fiscal/agent for CD services and that the companion shall not be reimbursed for services provided effective on the date and thereafter that the criminal record check verifies that the companion has been convicted of a crime pursuant to § 37.2-416 of the *Code of Virginia*.	§ 37.2-416 of the *Code of Virginia*	Conforms language to current practice where the fiscal/agent conducts the criminal background check and CPS Central Registry Check (for individuals providing services to minors) for individuals receiving CD services and defines when reimbursement can be made to the individual providing services.
	Crisis stabilization (formerly at 12VAC30-120-227) DBHDS licensing requirements are revised for crisis stabilization providers. **Personal assistance/respite (formerly 12VAC30-120-233)**		To comply with DBHDS Division of Licensing requirements.
	Previous requirements that assistants must complete a training curriculum consistent with DMAS requirements from a training program approved by DMAS is deleted.		This change is in response to a provider advisory group request that the DMAS curriculum be eliminated,

	Instead, providers shall ensure that attendants have completed an educational curriculum of at least 40 hours of study and that contains the specified elements. The training must be taught by a registered nurse.		allowing providers to develop their own programs.
	Respite hours are covered up to 720 hours in a 12 month period.		Without reducing the number of covered hours, DMAS is changing its prior authori-zation (service authorization) to six months increments.
	Define that a criminal record check and Child Protective Services (CPS) Central Registry Check (for services provided to minors) shall be requested by the vendor fiscal/agent for CD services and that the companion shall not be reimbursed for services provided effective on the date and thereafter that the criminal record check verifies that the companion has been convicted of a crime pursuant to § 37.2-416 of the *Code of Virginia*.		Conforms language to current practice where the vendor fiscal/agent conducts the criminal background check and CPS Central Registry Check (for persons providing services to minors) for individuals receiving CD services and defines when reimbursement can be made to the individual providing services.
	Add that the supervisor or case manager, as appropriate, shall determine and document why no providers other than family members are available to care for the waiver individual.		Existing regulations require that family members not serve as companions unless there is objective written document-tation as to why no other providers are available to provide the service. This amendment clarifies who is responsible for this determination.
	Add to the list of conditions prohibiting compensation for services when an attendant is determined by a local DSS to have abused or neglected elderly or incapacitated persons.		To ensure health, safety, and welfare of waiver individuals.
	Case manager's responsibility for the completion and updating of the DMAS-225 form (LTC Communication Form) is addressed. Monthly monitoring of the patient pay amount by the provider who has		A provider requested only 'periodic' monitoring of waiver individuals' income information. If providers do not check on a monthly basis

	the greatest financial responsibility is required for the purpose of maintaining current waiver individual monthly income information.		and the waiver individual's patient pay amount changes, then the provider will not be able to collect any increased amounts after the fact. The individual's money will be spent on other things and the provider will have to absorb a loss because the DMAS claims payment system assumes the provider is collecting the correct patient pay amount. Such amounts cannot be billed to DMAS. This monthly monitoring requirement is a protection for the provider not a punitive requirement.
1070 Payment for services	This new separate section describes how waiver services are reimbursed and states that there shall be no duplication of services.		This section is being added to all Medicaid waiver regulations for consistency.
1080 Utilization review; level of care reviews.	This new separate section describes the reevaluation of service need and quality management and utilization reviews.		This language is being added to all Medicaid waiver regulations for consistency of regulatory format. Level of care reviews and re-evaluations were previously addressed in 12VAC30-120-213F and 12 VAC30-120-215D.
1088 Waiver waiting list.	This is a new separate section to describe waiting list criteria for the MR/ID waiver, including criteria for the urgent category. Regulations establish DBHDS' authority to provide guidance to CSBs/BHAs to ensure a consistent statewide process to select individuals from the urgent waiting list to occupy available slots. Urgent criteria are used to determine who must be served first, based on the individual's needs at the time a slot becomes available and not on any predetermined numerical or chronological order.		This language is being added to all Medicaid waiver regulations for consistency across waivers' regulatory format. Waiting lists were previously addressed in 12VAC 30-120-213E.

1090 Appeals	This is a new separate section added to set forth agency appeal rights and requirements for both providers and individuals receiving services.		This language is being added to all Medicaid waiver regulations for consistency. Appeals were previously addressed in 12VAC30-120-213D.